ATTENTION HEALTH CARE PROVIDERS:
Please report relevant clinical findings about this disease event to the local health department.

NC EDSS PART 2 WIZARD
COMMUNICABLE DISEASE

Is/was patient symptomatic for this disease? □ Y □ N □ U

If yes, symptom onset date (mm/dd/yyyy): __/__/____

CHECK ALL THAT APPLY:
Fever .............................................................. □ Y □ N □ U
Headache ............................................................ □ Y □ N □ U
Muscle aches/pains (myalgias) .......... □ Y □ N □ U
Skin rash ......................................................... □ Y □ N □ U
Thrombocytopenia .......................... □ Y □ N □ U
Leukopenia ..................................................... □ Y □ N □ U
Anemia ......................................................... □ Y □ N □ U
Elevated liver enzymes ......................... □ Y □ N □ U

NOTES:

CLINICAL FINDINGS

Acute respiratory distress syndrome (ARDS) ................................ Y N U
Acute renal failure ........................................ Y N U
Disseminated intravascular coagulation ................................ Y N U
Specify ..............................................................

Other symptoms, signs, clinical findings, or complications consistent with this illness ................................ Y N U
Specify:

HOSPITALIZATION INFORMATION

Was patient hospitalized for this illness >24 hours? □ Y □ N □ U
Hospital name: _____________________________________________________________
City: _____________________________ State_______ ZIP_____________________
Hospital contact name: _____________________________
Telephone: _______ - _______
Admit date (mm/dd/yyyy): __/__/____
Discharge date (mm/dd/yyyy): __/__/____

REMEMBER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.

NAME OF LABORATORY _____________________________
City___________________________ State_______ ZIP_____________________

LAB RESULTS

SEROLOGIC TESTS
Indicate Y(es) or N(o) ONLY if the test was performed.

SEROLOGY 1
Collection Date (mm/dd/yyyy) _____________________________
Specimen # __________________
Titer/Result __________________
Positive? □ Y □ N

SEROLOGY 2
Collection Date (mm/dd/yyyy) _____________________________
Specimen # __________________
Titer/Result __________________
Positive? □ Y □ N

Other test: __________________
Titer/Result __________________
Positive? □ Y □ N

COMMENTS/DETAILS:

OTHER DIAGNOSTIC TESTS

Positive? □ Y □ N

PCR

Immunostain □ Y □ N

Culture □ Y □ N

Other Diagnostic Tests?

Other test: __________________

DATE OF DEATH (mm/dd/yyyy): __/__/____

DIED FROM THIS ILLNESS? □ Y □ N □ U
 Died? □ Y □ N □ U

 other test: __________________

CLINICAL OUTCOMES

Discharge/Final diagnosis: _____________________________

Survived? □ Y □ N □ U

Died? □ Y □ N □ U

Died from this illness? □ Y □ N □ U

Date of death (mm/dd/yyyy): __/__/____

Other symptoms, signs, clinical findings, or complications consistent with this illness ................................ Y N U
Specify:

PREDISPOSING CONDITIONS

Any immunosuppressive conditions □ Y □ N □ U
Please specify:

NOTES:
**TREATMENT**

Did patient take an antibiotic as treatment for this illness? .......................................................... □ Y □ N □ U

If yes:
- Check all antibiotics that apply:
  - Doxycycline
  - Chloramphenicol
  - Unknown
  - Other (specify): ______________

Date antibiotic began (mm/dd/yyyy): __________

If no:

Did patient refuse treatment? .......................................................... □ Y □ N □ U

Comments/details:

**VECTOR EXPOSURES**

During the 14 days prior to onset of symptoms, did the patient have an opportunity for exposure to ticks? .......................................................... □ Y □ N □ U

Exposed on (mm/dd/yyyy): __________

Until (mm/dd/yyyy): __________

Frequency: □ Once □ Multiple times within this time period □ Daily

Exposure setting: ______________

City/county of exposure: ______________

State of exposure: ______________

Country of exposure: ______________

Was the tick embedded? .......................................................... □ Y □ N □ U

How long? __________

□ Hours □ Days □ Unknown

Notes:

**VACCINE**

Has patient/contact ever received any other vaccine or immune globulin related to this disease? .......................................................... □ Y □ N □ U

Vaccine type: ______________

Date of administration (mm/dd/yyyy): __________

Source of this vaccine information: ______________

**TRAVEL/IMMIGRATION**

The patient is:

- Resident NC
- Resident of another state or US territory
- None of the above

Did patient have a travel history during the 14 days prior to onset? .......................................................... □ Y □ N □ U

List travel dates and destinations: ______________

Additional travel/residency information:

**CASE INTERVIEWS/INVESTIGATIONS**

Was the patient interviewed? .......................................................... □ Y □ N □ U

Date of interview (mm/dd/yyyy): __________

Medical records reviewed (including telephone review with provider/office staff)? .......................................................... □ Y □ N □ U

Specify reason if medical records were not reviewed:

Notes on medical record verification:

**GEOGRAPHICAL SITE OF EXPOSURE**

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

- In NC
- Outside NC, but within US

City

State

County

- Outside US

City

State

County

□ Unknown

Is the patient part of an outbreak of this disease? .......................................................... □ Y □ N

Notes: